VANGUARD
PLASTIC & RECONSTRUCTIVE SURGERY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR INFORMATION

We are required to maintain the privacy of your protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). Your "protected health information" is information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present, or future physical or mental health or condition, or payment for the provision of your health care.

If other federal laws or state laws provide more stringent protection for the privacy of your medical information, we will follow these other laws.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.

We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our

operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a copy of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can file a complaint with us if you feel we have violated your rights by contacting our HIPAA contact person or office. We will not retaliate against you for filing a complaint.

To file a complaint with our organization, please submit your request in writing to:

HIPAA REPORTING CONTACT INFORMATION

Jennifer Sartor, Chief Compliance Officer
ARSA
200 Schulz Drive, Floor 2
Red Bank, New Jersey 07701
jsartor@arsahealth.com

You can file a complaint with the U.S. Department of Health and Human Services' Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care or

payment related to your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these following cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes and 42 CFR Part 2 SUD counseling notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Treatment

We may share your information for treatment activities of another provider involved in your care.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Payment

We can use and share your health information to bill and get payment from health plans or other entities or individuals.

Example: We give information about you to your health insurance plan so it will pay for your services

Health Care Operations

We may use and share your medical information for our health care operations, and to contact you when necessary. A few examples are using information about you for:

- Improving the quality of the care we give you
- Disease management, wellness management, or population health programs
- Patient surveys
- Training students
- Business planning and administration
- Resolving patient complaints
- Getting or keeping an accreditation
- Compliance and legal services

We may also share your protected health information with people or companies (called business associates) we use to help us with our operations.

Clinical Photography and Imaging

As part of your care, we may take photographs, videos, or other images of you before, during, or after treatment for purposes of documenting your treatment, monitoring progress, and consultation among your care team. These images become part of your medical record and are used and shared for treatment, payment, and health care operations like any other health information described in this Notice.

We will not use your photographs or images for marketing, educational presentations, publications, our website, or social media without your separate written authorization. You may withdraw this authorization at any time, in writing, except to the extent we have already used or shared the images based on your earlier authorization.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet legal requirements before we can share your information for these purposes.

Help with public health and safety issues

We may share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We may use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, and we may share it when those laws allow it. For example, if the Department of Health and Human Services wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We may share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We may use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We may share health information about you in response to a court or administrative order, or in response to a subpoena.

Proof of Immunization

We may disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose information necessary for your health and the health and safety of other individuals to the institution.

42 CFR Part 2 Substance Use Disorder Records

Part 2 SUD records are records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

Written patient consent is required for uses and disclosures of Part 2 substance use disorder records (SUDs) for treatment, payment, and healthcare operations (TPO). This consent may be on a single consent form. Non-TPO disclosures of these SUD records require separate, specific consent.

We will only use or disclose Part 2 SUD records in a civil, criminal, administrative, or legislative proceeding against you when:

- You provide written consent for such use or disclosure; or
- A court orders the use or disclosure after provision of appropriate notice and an opportunity to be heard, AND a subpoena or other legal mandate compels the disclosure.

Our Responsibilities

- We are required by law to maintain the privacy of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

Other Uses and Disclosures of Health Information

Other ways we share and use your health information not covered by this notice will be made only with your written authorization. If you authorize us to use or disclose your health

information, you may cancel that authorization, in writing, at any time. However, the cancellation will not apply to information we have already used and disclosed based on the earlier authorization.

Changes to the Terms of this Notice

We may change the terms of this notice at any time and the changes will apply to all health information we have about you. The current notice will be available upon request and on our website.

https://www.vapsfl.com/

Florida Addendum

This section describes protections under Florida law.

- **Data Breach Notification:** Under Florida's Information Protection Act (Fla. Stat. § 501.171), we must notify you within 30 days after we determine that a breach of your unencrypted personal information has occurred (with a possible 15-day extension for good cause). This is a shorter deadline than HIPAA's 60-day standard, and we will follow Florida's 30-day deadline.
- **Genetic Testing and Information:** Under Florida law (Fla. Stat. § 760.40), we may only perform DNA analysis (genetic testing) with your express, informed consent. The results are your exclusive property, are confidential, and may not be disclosed without your express consent.
- **HIV/AIDS Information:** Under Florida's Omnibus AIDS Act (Fla. Stat. § 381.004), HIV test results and related information are confidential and may not be disclosed without your authorization, except as permitted by law.
- **Mental Health Records:** Under the Florida Mental Health Act (Fla. Stat. § 394.4615), your mental health clinical records are confidential and may only be disclosed as authorized by law.
- **Minor Consent Services:** Florida law permits minors to consent to certain healthcare services on their own, including diagnosis and treatment of sexually transmitted infections (Fla. Stat. § 384.30) and substance use disorder treatment (Fla. Stat. § 397.601(4)). When a minor consents to these services on their own, the related records receive additional confidentiality protection.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare

operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Clinical photography and imaging, where applicable, are addressed under a separate Photography Consent form.

Patients Name: _____

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Name: _____

Relationship to Patient: _____

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

■ Individual refused to sign

■ Communication barriers prohibited obtaining the acknowledgment

■ Other (please specify) _____

EFFECTIVE DATE: 07/01/2026